

## **A Response to Professor Fred Friedberg's Editorial about CBT**

Professor Fred Friedberg asks why cognitive behavioural therapy (CBT) is so vilified in the chronic fatigue syndrome community.

He opens his Editorial by stating: "*Cognitive behaviour therapy (CBT) is a well-established psychosocial intervention for psychiatric disorders, pain management and stress related to medical conditions*" (Editorial: Cognitive-behavior therapy: why is it so vilified in the chronic fatigue syndrome community? Fatigue, Biomedicine, Health & Behavior 2016:vol 4: no:3:127-131) but ME/CFS is not, and never has been, a psychiatric disorder and CBT has no more role in its management than in the management of multiple sclerosis, MND, Parkinson's Disease, malignancies or other autoimmune disorders such as lupus or RA.

CBT is not mandated as the primary management approach in those other disorders, so why in ME/CFS?

Patients with ME/CFS do not summarily reject any intervention that would help them: what they reject is a psychosocial intervention that is used with the intention of changing their correct perception that they are very sick with an organic disease, not with a behavioural disorder that is curable by "cognitive re-structuring" if they would only co-operate.

Friedberg appears to assume that, where there is stress related to a medical disorder, CBT supports patients to help them cope better with their disease.

However, a key consideration which he fails to mention is the significant difference between supportive CBT and directive CBT.

In relation to ME/CFS, in the UK PACE trial CBT was not supportive but directive: Professor Sir Simon Wessely, currently President of the Royal College of Psychiatrists, has publicly stated: "**CBT is directive - it is not enough to be kind or supportive**" (New Statesman, 1<sup>st</sup> May 2008).

No amount of directive "cognitive re-structuring" can result in "recovery" from such a multi-system inflammatory disease process as has been demonstrated in ME/CFS.

The Centres for Disease Control (CDC) has archived its toolkit that recommended CBT and GET as interventions for ME/CFS (<http://www.cdc.gov/cfs/toolkit/archived.html>) and the National Institutes for Health (NIH) has produced a report which acknowledges the harm done to patients (<http://annals.org/article.aspx?articleid=2322804>); their conclusions were based on comprehensive reviews of over 9000 peer-reviewed research papers and testimony from expert researchers and clinicians.

Does this not provide the answer to Friedberg's question as to why CBT is so vilified in the ME/CFS community?

Diverting scarce resources from biomedical research by funding psychosocial interventions that have been conclusively proven to be ineffective can only harm patients further.

Money must now urgently be made available by institutions such as the MRC for research that is relevant to the disorder; for example, Professor Faisal Khan (recently appointed to the Chair of Cardiovascular Sciences, Division of Molecular and Clinical Medicine at the University of Dundee) is working on NRF2 (nuclear receptor factor 2) in ME/CFS patients and his work ties in with the study by Japanese researchers who looked at index markers in ME/CFS patients with dysfunction of TCA (the tricarboxylic acid cycle, also known as the Krebs cycle, which is the biochemical pathway used to generate energy) and urea cycles (<http://www.nature.com/articles/srep34990>).

Behavioural researchers who for over 30 years have shown disregard for the scientific process should have no influence on future research.

Patients with ME/CFS do not need "behavioural" guidance from a profession which has visited such harm upon them.

To spell it out: directive CBT does not work for patients with ME/CFS and it is time that those psychologists and psychiatrists who insist that it does returned to reality.

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<http://www.margaretwilliams.me/2016/response-to-professor-fred-friedberg.pdf>